REFERRAL FOR THERAPEUTIC VENESECTIONS

pathlab

PATIENT DETAILS	
Surname:_____	NHI:_____
First Name(s):_____	Date of Birth:_____
Address:_____	Phone:(Hm)_____
_____	Phone:(Wk)_____
_____	Mobile:_____

REFERRING DOCTOR

I request therapeutic venesection for the above patient, who is under my clinical care.

- I confirm that my patient meets acceptance criteria for therapeutic venesection.
- I confirm that my patient is medically 'fit' for therapeutic venesection
- I am aware that I will be responsible for monitoring of the patient and will advise Pathlab of changes to the venesection schedule or withdraw from service if no-longer medically 'fit' for venesection.

Name: _____

Contact Details: _____

Date of Request: _____/_____/_____ Doctor's Signature: _____

DIAGNOSIS-REASON FOR VENESECTION

TEST RESULTS – Initial Referral ONLY
(please include copies of relevant test results and/or Haematologist correspondence)

Ferritin, %saturation / Haemoglobin / Haematocrit:	Genetic Testing Result:
Clinical Complications (*hypertension, ,cardiac/pulmonary disease etc /* Additional information*:*	
Medications:	

VENESECTION – frequency, duration and targets.

For Haemochromatosis and Iron overload – See Primary care management Guideline.

Volume to be venesected:	…… ml *(not to exceed 500 ml)*
Frequency of venesection / Number of venesections required i.e. Care plan	……
	……
	……
Target ferritin e.g. ferritin below 50 ug/L	……
	……
Polycythaemia patients– indicate target haematocrit: (A venesection will be performed when the HCT exceeds this target)	……

We will collect the blood sample at the time of venesection, with CBC, Ferritin and Iron profile to be performed and forward the results to the requesting Clinician.

Please return completed form to:

Need to add appropriate Info for each site